No. 93-120

IN THE
SUPREME COURT OF THE UNITED STATES
October Term, 1993

THOMAS JEFFERSON UNIVERSITY
d/b/a Thomas Jefferson University Hospital,
Petitioner,

v.

DONNA E. SHALALA, SECRETARY
Department of Health and Human Services,
Respondent.

ON WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

REPLY BRIEF FOR THE PETITIONER

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INTRODUCTION

The Secretary's brief is a creative exercise in *post hoc* rationalization of her policy which does not hide the fact that her interpretation of the relevant regulation is contrary to the 20-year history of that regulation and is completely inconsistent with the Secretary's regulatory scheme. Indeed, a review of the regulation on its face, its place in the Secretary's regulatory scheme, the Medicare statute it is supposed to implement, and the Secretary's

previous policies and statements in this area readily reveal that the Secretary's interpretation of the regulation offered here is inconsistent with the Medicare statute, arbitrary, capricious and not supported by substantial evidence.

ARGUMENT

I. THE SECRETARY'S INTERPRETATION OF THE "COMMUNITY SUPPORT" LANGUAGE IN SECTION 413.85(c) IS INCONSISTENT WITH HER REGULATORY SCHEME AND WITH HER PREVIOUS INTERPRETATION OF THE GME REGULATIONS

The Secretary argues here that the "community support" language found in 42 C.F.R. § 413.85(c) is a separate and independent bar to reimbursement of costs incurred in connection with a hospital's GME programs. Respondent's Br. at 17-18. The problem with the Secretary's claim is that it (a) is completely incompatible with her own regulatory scheme; (b) is totally inconsistent with her 20-year history of treatment of GME cost claims; and (c) results in absurd reimbursement decisions that are directly contrary to express Congressional intent. The Secretary's attempt in her brief to account for these inconsistences is entirely unpersuasive.

A. The Secretary's Interpretation of the "Community Support" Language Makes No Sense In the Context of Her Regulatory Scheme

The Secretary's own regulatory scheme contradicts her claim that section 413.85(c) is a force, separate and independent from paragraph (g), for analyzing the total amount of a provider's reimbursement for GME costs in a given year. Paragraph (a) sets forth the general rule for

payment of GME costs. According to this provision, "a provider's allowable cost may include its net cost of approved educational activities, *as calculated under paragraph (g)*." 42 C.F.R. § 413.85(a) (1985) (J.A. 40) (emphasis added). Paragraph (a) makes no mention of deducting or accounting for "community support" under paragraph (c).

Paragraph (g), as it existed during the cost year at issue here, provided that net costs of approved activities are determined by deducting from a provider's total costs of those activities "revenues it receives from tuition." 42 C.F.R. § 413.85(g) (J.A. 41). Previously, the regulation had required that other forms of revenue -- those the Secretary now claims constitute "community support" (*i.e.*, grants, gifts and donations) -- should also be deducted from total costs to determine the net allowable GME costs. *See* 20 C.F.R. § 405.421(b)(2) (1966) (J.A. 34) and § 405.421(g)(1) (1980) (J.A. 39). The Secretary modified the regulation prior to the cost year at issue here to provide that those items need not be offset from total costs to determine net allowable GME costs. 49 Fed. Reg. 234, 296 (Jan. 3, 1984) (J.A. 39-40). The Secretary has concluded that the offset of such contributions "appears to dilute the effect of the contribution," and therefore, "may discourage private philanthropy." *See* 48 Fed. Reg. 39,752, 39,757 (Sept. 1, 1983) (reprinted in Appendix to Brief of *Amici Curiae* State of Ohio, *et al.*, at 15a-16a).[1]

Here, however, the Secretary advances the position that the very items which she eliminated from the offset provisions of paragraph (g) can nevertheless be used to reduce claims for GME reimbursement under paragraph (c). Respondent's Br. at 17-18. The Secretary repealed the offsets under paragraph (g) because she found they discouraged philanthropy. She does not explain why denying

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[1] *See also* Argument section I.C., *infra*.

reimbursement of current costs on the basis of past grants under paragraph (c) does not *also* discourage philanthropy. The Secretary's failure to articulate a coherent policy on community support means her position in this case is not entitled to deference.

B. The Secretary's Interpretation of the "Community Support" Language is Contrary to 20 Years of Prior Interpretations

In addition to lacking any support in common sense or logic, the Secretary's interpretation of "community support" as advanced here is contrary to her own previous statements and actions.

The Secretary's current interpretation of paragraph (c) is completely inconsistent with her prior rulemaking under paragraph (g). If, as the Secretary here asserts, paragraph (c) is a separate bar to recovery of GME costs where certain items -- gifts, grants and donations -- have in the past been received by the hospital, then it makes no sense ever to have included gifts, grants and donations as items to be deducted from total costs under paragraph (g). Yet for years those items were so included. Moreover, when she revised her regulations to eliminate the offset for gifts, grants and donations in paragraph (g), the Secretary failed to point out that these exact same items were still to be counted as "community support" and must still be analyzed when "satisfying" the regulation's "independent condition" under paragraph (c). Respondent's Br. at 28-29.[2]

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[2] This is not simply "establish[ing] policy by omission." Consider how the Secretary's past actions and current interpretation interact. In 1984, the Secretary eliminated the offset under paragraph (g) for grants, gifts and donations. The next year, every hospital with GME costs which previously had been deducting those items from total costs was (continued...)

As described in the Brief of *Amici Curiae* the American Hospital Association, *et al.*, the Secretary's own forms for submitting cost reports contain no reference to "community support," much less a line item or instruction regarding where and how a hospital is supposed to account for the "community support" the Secretary now claims is and always has been required by paragraph (c). *See* AHA Br. at 13-14 and n.6. Yet the forms *do* and always have contained instructions regarding the deduction of items required to be offset under paragraph (g). The Secretary did not even respond to this argument. Moreover, the Secretary's Provider Reimbursement Manual ("PRM"), a detailed policy manual, nowhere mentions "community support" in the context of GME. Certainly the PRM contains no instructions for how a fiscal intermediary is to determine that the "independent condition" set forth in paragraph (c) has been "satisfied."

In addition, the Secretary has publicly admitted that for the first 20 years of the Medicare program (a period that encompasses the year under review), Medicare imposed no deduction or ceiling based on "community support." In the Preamble to a 1985 rule which was to provide a one-year

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[2](...continued)
allowed, in effect, to increase its net allowable GME costs by the amount of those gifts, grants and donations. According to the Secretary, however, paragraph (c), which "is concerned with whether costs have historically been paid from sources other than Medicare in the *past*," places an "independent condition" on the availability of Medicare reimbursement to these hospitals, that "must be satisfied before payment can be made." Respondent's Brief at 28-29 (emphasis in original). Obviously, these hospitals have received funds *other than Medicare* in the past (*e.g.*, the gifts, grants and donations previously offset from total costs under (g)) from which costs have been paid. Thus, the "independent condition" of paragraph (c) cannot be satisfied, and the Secretary is justified in refusing to pay the increased GME costs. Although the Secretary denies that her interpretation gives with one hand and takes away with another (Respondent's Br. at 28), it obviously does.

moratorium on increases in reimbursement for medical education costs, the Secretary stated:

> we believe that *after 20 years of very generous support by the Medicare program, that it is time to implement the Congressional intent* that local communities assume a greater role in the costs of medical education.

50 Fed. Reg. 27,722, 27,723 (July 5, 1985) (emphasis added).[3] She also referred to "Medicare's policy of basing its reimbursement on 100 percent of the reasonable direct costs of approved educational activities," 50 Fed. Reg. 21,026 (May 21, 1985), and to the Medicare policy of providing "virtual open-ended funding" for medical education. 50 Fed. Reg. at 27,723.[4] Obviously, the Secretary was not then interpreting paragraph (c) to provide an "independent" basis for limiting GME payments.

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[3] The Secretary's proposal to establish a one-year moratorium on increases in medical education costs was codified at 42 C.F.R. § 405.421(a)(2) (1985). The moratorium was to apply to a hospital's first cost reporting year beginning or after July 1, 1985 -- which would have been Petitioner's first cost reporting year beginning after the year under appeal in this case. Congress enacted legislation which precluded the Secretary from implementing the moratorium. *See* Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, § 9202(i), enacting 42 U.S.C. § 1395x(v)(1)(Q), *reprinted in* 1986 U.S.C.C.A.N. (100 Stat.) 82, 177. Instead, Congress enacted the per resident methodology in 42 U.S.C. § 1395ww(h). Pub. L. No. 99-272, § 9202(a), 1986 U.S.C.C.A.N. (100 Stat.) at 171.

[4] These statements demonstrate that the Secretary's claim here that Medicare is the "payor of last resort" for medical education costs, and her attempt to suggest that the program has always considered that medical education costs need only partially be paid is simply not true. Respondent's Br. at 30. The Secretary is engaged in *post hoc* rationalization of this policy, but the explanation is totally inconsistent with her public record on the issue.

Significantly, she believed that additional regulatory action was required to impose such a limit.

C. The Secretary's Interpretation of "Community Support" Results In Absurd Reimbursement Decisions, Clearly Contrary to Express Congressional Intent

The Secretary's analysis of section 413.85(c) presented here -- suggesting that gifts and grants can be used to reduce reimbursable costs -- is flatly inconsistent with the Medicare statute. In the Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499, § 901(a)(1), *reprinted in* 1980 U.S.C.C.A.N. (94 Stat.) 2599, 2611, enacting 42 U.S.C. § 1320b-4 (App. 1a), Congress codified the Secretary's then-existing practice that *unrestricted* gifts, grants and donations were not to be offset from the operating costs of non-profit hospitals when calculating reimbursable Medicare costs. Congress also gave the Secretary the authority to eliminate the deduction for "[t]hose types of donor designated grants and gifts (including grants and similar payments which are made by a governmental entity) . . . which the Secretary determines, in the best interests of needed health care, should be encouraged." App. 1a.[5] The Secretary's interpretation of section 413.85(c), which treats *all* grants, gifts and donations as "community support," the past existence of which can be used to deny GME reimbursement, is contrary to Congress' intent in passing the legislation.

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[5] Pursuant to this authority, the Secretary promulgated the amendments to 42 C.F.R. § 405.423 (eliminating the deduction for donor-restricted gifts, grants and endowment income from the calculation of "reasonable" Medicare costs), and 42 C.F.R. § 413.85(g) (eliminating the deduction for donor-restricted gifts, grants and endowment income from the calculation "net" GME costs). *See* Appendix to Brief of *Amici Curiae* State of Ohio, *et al.*, at 15a-16a.

> It is the intent of the conference committee that the prohibition against deducting gifts, grants, endowments, and income therefrom, shall apply *indirectly as well as directly* and preclude the Secretary from taking into account the presence of charitable funds generated from gifts, grants or endowments which have not been designated by the donor for paying any specific operating costs as a reason for denying *any reimbursable expense* . . . .

H.R. Conf. Rep. No. 1479, 96th Cong., 2d Sess. 140 (1980), *reprinted in* 1980 U.S.C.C.A.N. 5903, 5931 (emphasis added) (App. 2a-3a). The Secretary cannot claim that where grants are given to a medical school and not a hospital, the statute is inapplicable. Offsetting the hospital's cost claim by grants received by its related medical school "indirectly" reduces the hospital's reimbursement.

Reading the regulation according to the Secretary's current interpretation simply makes no sense applied to a real reimbursement situation. According to the Secretary, "subsection (g) calculates 'net cost' as a function of the availability of outside funds *during the cost reporting period in question*. Subsection (c), in contrast, is concerned with whether costs have historically been paid from sources other than Medicare in the *past*. Thus, each regulation places an independent condition on the availability of reimbursement under Medicare, and each must be satisfied . . . ." Respondent's Br. at 28-29. But how does this work as applied in the real world?

Assume Hospital A is a licensed operator of GME programs and a division of a university that also operates a medical school. Hospital A's GME programs are staffed by physicians who are actually employed by (that is, paid by) the medical school. Both the hospital and the medical school are divisions of a single entity -- the university. In Year 1,

Hospital A's medical school receives a grant from a private donor of $1,000. Section 413.85(g), the Secretary acknowledges, provides that the $1,000 grant need not be deducted from Hospital A's total costs, and thus, has no effect on Hospital A's allowable Medicare GME program reimbursement during the year in question.

In Year 2, the $1,000 grant is continued. As in Year 1, the $1,000 grant received in Year 2 is not required to be offset from Hospital A's total costs in Year 2 to determine total allowable costs. 42 C.F.R. § 413.85(g). But how is the "independent condition" provided by paragraph (c) to be satisfied? Is the Hospital required to deduct the $1,000 grant received in Year 1 from Year 2 total costs -- to reflect that in the past $1,000 in revenues were received from sources other than Medicare? This doesn't seem quite right -- why is the $1,000 deductible in Year 2 when it was not in Year 1? Why should the $1,000 received in Year 1 be deducted from Year 2 costs when the $1,000 actually received in Year 2 need not be?

The Secretary does not address any of these hard questions. Nor does she explain why requiring an offset in the year the grant is actually received violates Congressional policy by discouraging private donations, but using the existence of past grants to deny current reimbursement does not. Instead she blithely asserts generalizations, "each regulation places an independent condition on the availability of reimbursement . . . ." (Respondent's Br. at 29) without offering a single explanation for how this generalization is to be implemented in the context of her regulatory scheme. As noted *supra* at 5, the Secretary has never issued any regulations or interpretations explaining *how* this "independent condition" is actually to be implemented. The obvious conclusion is that paragraph (c) is not an "independent condition" at all, but rather, as Petitioner asserts, serves to provide the rationale for the more specific provisions in the medical education regulation.

D. The Secretary's Attempts to Dismiss Her Inconsistent Interpretations Of "Community Support" Are Unconvincing

The Secretary's attempts to explain away her inconsistent interpretations of "community support" are unpersuasive. First, she claims that her previous treatment of the Petitioner cannot be *proved* to be inconsistent because the record does not demonstrate *why* the costs claimed for the first time in 1974 were considered to be reimbursable. Respondent's Br. at 35. The Secretary speculates that the Hospital's claim might fall within one of the distinctions she identifies in her brief (although these distinctions cannot be found anywhere in the Secretary's regulations or policy guidelines) such as that the Hospital had experienced "unprecedented" costs or costs for "new" programs. Respondent's Br. at 36. She suggests that her position might not be inconsistent at all if the pre-1974 costs had been paid by the provider, rather than the medical school, and if the presumption of community support were somehow overcome. *Id.*

The Secretary's musings and speculation are contradicted by the record and by the Administrator of HCFA, whose decision is the decision of the Secretary. The Administrator concluded that "[p]rior to 1974, the Provider's educational program was *solely* supported by the community, *i.e.*, tuition, hospital fees, grants, bequests, and state funded support from Pennsylvania and Delaware." Pet. App. 32a (emphasis added). These are the *exact* same sources of funding the Secretary argues had previously supported the medical school and justified denying Petitioner's 1985 claim. Moreover, the fiscal intermediary (the Secretary's agent for calculating the amount of reimbursement owed in the first instance) also claimed at the Provider Reimbursement Review Board ("PRRB") that the Hospital's 1974 claim for GME reimbursement was a "redistribution" of costs from the

"community" and the medical school to Medicare. A.R. 41, 59.

The Secretary's argument is disingenuous at best. First she argues that it is perfectly appropriate for her to presume that if a hospital has been operating GME programs without Medicare payments in the past, those programs must have been supported by the community and can (and indeed are required by the community support language in paragraph (c)) continue to get by without Medicare payments. Respondent's Br. at 30-31. When confronted with the evidence that *this* hospital had in fact been operating GME programs from the beginning of the Medicare program until 1974 with no Medicare support, but then requested and received for the first time Medicare payment for GME costs beginning in 1974, the Secretary denies that this is an inconsistent application of her policy because the record does not reveal why payment was made. The record does reveal, however, that prior to 1974, the program *solely* was supported by the community, under the Secretary's current interpretation of that term. Thus, there is no question that the Secretary's treatment of the Hospital's 1985 request for reimbursement of GME costs is a departure from her past practices.[6]

Second, the Secretary's attempt to avoid the most irrational aspects of application of her new interpretation by

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[6] The Secretary's claim that there was no need to adopt this interpretation prior to 1985 because there was a "surge" in claims for increased Medicare reimbursement is undermined by this same record evidence. Obviously, hospitals had made claims for increased GME reimbursement, indeed, they had made *first time* claims for GME reimbursement prior to the mid-1980s. Petitioner made a first time claim in 1974. The Oregon University Health Science Center made a first time claim in 1982-83. Petitioner's Br. at 22-24. And many hospitals were making claims for related-party medical school GME reimbursement in the mid-1970s because that is obviously what triggered the agency to issue Intermediary Letter 78-7 instructing intermediaries how to treat such claims.

claiming that certain GME costs not previously claimed might nevertheless be reimbursed is totally unsupported. According to the Secretary's brief, "if a provider claims a cost for a new educational service that has never previously been provided (and thus never been paid for by the community), reimbursement would be permitted under subsection (c)." Respondent's Br. at 29. This argument suggests that no program in existence prior to 1966 could qualify for Medicare reimbursement, yet that obviously is not what happened.

Finally, the Secretary fails adequately to address her own public pronouncements of policy which are inconsistent with her current claim that paragraph (c) provides "independent conditions" which must be separately satisfied to determine a provider's ultimate reimbursement. For example, in the preamble to the 1989 GME regulation, the Secretary was specifically asked to address "whether there is a *redistribution* of GME costs when *State appropriations or other funding sources* are sufficient to cover the costs of operating the medical school." 54 Fed. Reg. 40,286, 40,302 (Sept. 29, 1989) (J.A. 43) (emphasis added). The Secretary's response to this question deals *only* with the provisions of paragraph (g) regarding deductions from total costs. It does not mention the "independent condition" provided by paragraph (c) that allegedly restricts the amount of GME reimbursement available when grants, gifts and other funding sources are available to support GME program costs. The Secretary justifies this blatant inconsistency by misstating the question. According to the Secretary, her answer's focus on paragraph (g) was appropriate because the "inquiry concerned the issue of 'offset'. . . ." Respondent's Br. at 34. The inquiry quite obviously did not concern "offset." It concerned redistribution in the context of a related party medical school which was supported by non-Medicare funds. According to the Secretary's position here, such funds are presumptive "community support." Her failure to address the "independent condition" of

paragraph (c) which she claims must be satisfied separately prior to determining a hospital's allowable GME reimbursement is powerful evidence that in 1989 at least she did not think that the community support language was implicated by the commenter's question.

II. THE SECRETARY'S CURRENT INTERPRETATION OF THE REDISTRIBUTION CLAUSE IS CONTRARY TO THE PLAIN MEANING OF THE REGULATION

The Secretary asserts that her interpretation of the redistribution clause of paragraph (c) should be upheld for many of the same reasons offered in support of her interpretation of the community support clause. Indeed, she basically merges the two concepts by asserting that she considers "financial support by an affiliated medical school for any aspect of the provider's educational programs as a form of 'community support'" (Respondent's Br. at 19), and thus, when a related-party medical school has previously borne costs of GME programs, not only is the redistribution principle violated, but so is the community support principle.[7]

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[7] The Secretary makes the remarkable claim that when the regulation is viewed from the perspective suggested here -- that a related-party medical school can properly be considered part of the "community," such that costs incurred by the related party are "community support" -- the Congressional purpose of increasing community support for GME programs is advanced. *See* Respondent's Br. at 19 n.11. This is absurd. When the Medicare statute was written, including the legislative history noting that communities were not supporting medical education programs, many teaching hospitals were affiliated with universities that also operate related-party medical schools. That is the same situation that exists today. Congress looked out at this landscape and said communities are *not* supporting graduate medical education. Until they do, Medicare must participate appropriately (that

(continued...)

There is no basis in the statute, the regulation or the Secretary's past practices for this interpretation. First, her interpretation completely ignores the related-party principle of her own regulation.[8] Pursuant to 42 C.F.R. § 413.17(a), the "costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable cost of the provider at the cost to the related organization." In addition, the Secretary has specifically recognized, as acknowledged in Intermediary Letter 78-7, that allowable hospital costs include the reasonable costs

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[7](...continued)
is, along with other purchasers of hospital services) in the payment of these costs. Twenty years later, the Secretary has gazed out over the same landscape and discovered that if she re-labels the participants she can "increase" community support. There is absolutely no evidence that Congress intended for the Secretary to come along and examine how costs were historically paid, re-label payment by related-party medical schools as "community" support, and thereby declare victory in the effort to increase community support for GME programs.

[8] The Secretary's claim that Petitioner has abandoned its objection to the Administrator's holding that general administrative expenses of the medical school are not reimbursable is incorrect. Respondent's Br. at 9-10 n.7. In its Petition for a Writ of Certiorari, Petitioner specifically noted that the Secretary's regulations actually provide that full *direct and indirect* costs are to be taken into account in calculating the "net cost" under section 413.85(g). *See* Petition for Writ of Certiorari at 4-5. As discussed in the briefs of Petitioner and *amici*, it is the Secretary who has abandoned this argument as an alternative basis for denial of Thomas Jefferson's claim, and of Ohio State University's claim. *See* Petitioner's Br. at 14 n.9. *See also* Brief of *Amici Curiae* American Hospital Assoc., *et al.*, at 7 n.5; Brief of *Amici Curiae* State of Ohio, *et al.*, at 8-9 n.5. Although the Secretary revised her statement of the Question Presented in her brief to eliminate the reference to Petitioner's costs as "otherwise reimbursable," she does not dispute Petitioner's contention that she has abandoned this issue.

incurred by a related medical school in support of a hospital's GME programs. *See* Pet. App. 64a.

The point of the related-party regulation is to recognize the reality of transactions between such entities, *i.e.*, that they are not arm's length transactions, but rather transfers between entities which are essentially alter egos. 42 C.F.R. § 413.17(c)(2). Since related organizations, such as a medical school and a hospital which are divisions of a university, are merely alter egos of each other, to claim that payment of costs by one of the entities is the equivalent of community support is absurd. The provisions of section 413.17(a) are very specific. Those specific provisions provide that the costs of a related organization *are* allowable hospital costs.[9] Moreover, the Secretary's specific instructions to intermediaries provides that where a medical school which is related to a hospital by common ownership provides services to the hospital's GME programs, the medical school's costs are allowable hospital GME costs. It is inappropriate to construe the general "redistribution" language in paragraph (c) to conflict with these specific provisions, particularly when such a construction is inconsistent with the plain wording of paragraph (c) itself.[10]

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[9] Significantly, nothing in the wording of section 413.17 suggests any exception for medical education costs. Moreover, specific recognition of the applicability of the related-organization principle to medical education costs is found in 42 C.F.R. § 405.481(a) (App. 3a). That provision defines "physician compensation" costs reimbursable by Medicare to encompass costs incurred by a provider or "entities related to the provider" under 42 C.F.R. § 413.17. *Id.*

[10] The Secretary erroneously accuses Petitioner of ignoring the redistribution language in paragraph (c). Petitioner has not ignored that language (the second phrase in the last sentence of paragraph (c)) but, like the *Ohio State* courts, has construed that language in light of the first phrase in the sentence, *i.e.*, "the intent of the program is to share in the support of educational activities customarily or traditionally carried on by
(continued...)

The Secretary also dismisses the array of evidence indicating she has never previously interpreted the redistribution provision in the manner she asserts here by claiming that she does not "establish policy by omission." Respondent's Br. at 32.[11] The record reveals that the Secretary has done much more than "establish policy by omission." She has in fact affirmatively asserted that the redistribution principle *does not* bar reimbursement of the clinical teaching costs incurred by a related-party medical school in support of a hospital's GME programs.

For example, in PRM § 404.2 (J.A. 56-58), the Secretary discusses redistribution in the context of nursing and paramedical training programs. The Secretary specifically distinguishes between clinical training programs -- the costs of which are always allowable -- and classroom training -- the costs of which are allowable only if the program is operated by the provider. According to the Secretary, the portion of section 404.2 which states, "[i]f the non-provider reduces its costs due to receiving provider support, such reduction constitutes a redistribution," is a "general rule" which is not "confined to the redistribution of classroom costs." Respondent's Br. at 24-26 n.14. A simple glance at section 404.2 reveals that this is a serious distortion.

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[10](...continued)
providers in conjunction with their operations." 42 C.F.R. § 413.85(c). *See Ohio State University v. Sullivan*, 777 F. Supp. 582, 586-87 (S.D. Ohio 1991), *aff'd*, 996 F.2d 122, 124 (6th Cir. 1993). As the Secretary's brief reflects, the Secretary has failed to give any effect at all to that critical language.

[11] As noted *supra* at 12-13, the Secretary's attempt to explain her failure to articulate the policy on "redistribution" she espouses here, in response to a public comment asking specifically for an explanation of "redistribution" in the context of a state-supported university operated GME program, is not persuasive.

Section 404.2 is divided into several sections. The quoted passage comes from a section labelled "Non-Provider-Operated Programs Supported By Providers." There, the Secretary instructs that costs incurred "which are related to the *classroom* portion [of a non-provider operated program] are allowable if . . . three criteria are met." The first criterion, under the discussion of allowability of *classroom* costs, is: "The provider's support does not constitute a redistribution of non-provider costs to the provider." J.A. 57.

As a further explanation of that criterion, the PRM offers the passage quoted by the Secretary. The Secretary's claim that this passage is a general limitation on reimbursement of medical education costs -- clinical or classroom -- is preposterous. On the contrary, what the manual says about clinical costs is: "Costs incurred for the clinical training at the provider are allowable." J.A. 56. *No* conditions or criteria are imposed on the allowability of those costs, and redistribution is not mentioned.

III. THE SECRETARY'S CLAIM THAT THE MEDICARE STATUTE GIVES HER UNFETTERED DISCRETION TO ESTABLISH ANY MEDICARE REIMBURSEMENT POLICY SHE WANTS IS WRONG

The Secretary's suggestion that she possesses essentially unbridled authority under the Medicare statute is plainly contradicted not only by the plain wording of the statute but by the case law. The two most significant statutory limits on the Secretary's authority which are relevant here are the requirements set forth in 42 U.S.C. § 1395x(v)(1)(A) that mandate reimbursement of actual costs necessary for the efficient delivery of needed health services and prohibit the shifting of Medicare costs to non-Medicare patients, and the requirement of 42 U.S.C. § 1320b-4 that for purposes of determining reasonable costs the Secretary

"shall not" deduct from operating costs unrestricted grants, gifts or endowments. Contrary to the Secretary's claim (Respondent's Br. at 22 n.12), courts of appeals do not "uniformly" uphold her regulations out of deference to the complicated nature of Medicare reimbursement. *See St. James Hosp. v. Heckler*, 760 F.2d 1460, 1470 (7th Cir.), *cert. denied*, 474 U.S. 902 (1985) ("a lesser degree of deference is required when reviewing the Secretary's actions under the Medicare Act's reimbursement provisions.").[12]

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[12] Indeed, Petitioner was able to identify easily nearly 30 cases striking down various of the Secretary's regulations on the grounds that they were contrary to the Medicare statute. A partial list of those cases includes: *St. Mary of Nazareth Hospital Center v. Heckler*, 760 F.2d 1311, 1315-19 (D.C. Cir. 1985) (Secretary's regulation relating to the practice of including labor/delivery patients as inpatients for purposes of calculating routine-cost Medicare reimbursement held invalid); *Humana, Inc. v. Heckler*, 758 F.2d 696, 703-07 (D.C. Cir. 1985), *cert. denied*, 474 U.S. 1055 (1986) (Secretary's regulation not permitting a revaluation of assets and an increase in equity capital in a stock acquisition when an acquired corporation is liquidated or merged into the acquiring corporation held invalid); *accord PIA-Asheville, Inc. v. Bowen*, 850 F.2d 739, 741 (D.C. Cir. 1988); *Bedford County Memorial Hospital v. HHS*, 769 F.2d 1017, 1023 (4th Cir. 1985) (Secretary's regulation which changed process by which hospitals are compensated for portion of their malpractice costs attributable to Medicare patients held invalid); *Presbyterian Hospital of Dallas v. Harris*, 638 F.2d 1381, 1386-88 (5th Cir.), *cert. denied*, 454 U.S. 940 (1981) (Secretary's disallowance of expenses incurred in the provision of free medical care to indigents under the Hill-Burton program held invalid); *University of Cincinnati v. Bowen*, 875 F.2d 1207, 1212 (6th Cir. 1989) (Secretary's policy regarding reimbursement of costs for payment of stipends and related overhead of time spent by residents working in outpatient clinics held invalid); *accord Loyola University of Chicago v. Bowen*, 905 F.2d 1061, 1072 (7th Cir. 1990); *St. John's Hickey Memorial Hospital, Inc. v. Califano*, 599 F.2d 803, 812-15 (7th Cir. 1979) (Secretary's policy regarding reimbursement for portion of costs incurred by a nursing education program held invalid); *Vista Hill Foundation, Inc. v. Heckler*, 767 F.2d 556, 561-66 (9th Cir. 1985) (Secretary's policy denying reimbursement for (continued...)

Moreover, numerous other courts have rejected Secretarial policies as inconsistent with the regulations or arbitrary or capricious.[13] Deference is not appropriate here because, as demonstrated in Petitioner's brief, and as the court found in *Ohio State University v. Sullivan*, 777 F. Supp. at 587, the Secretary's policy here violates the Medicare Act.

CONCLUSION

For the reasons set forth here and in its opening Brief, Petitioner respectfully prays that the Court reverse the judgment of the Court of Appeals for the Third Circuit, and direct the Secretary to reimburse the Hospital for the

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[12](...continued)
educational costs provided to children as a part of a therapy modality in a psychiatric hospital held invalid); *Mercy Community Hospital v. Heckler*, 781 F.2d 1552, 1556-58 (11th Cir. 1986) (Secretary's policy regarding recapture of depreciation payments made to Medicare provider in connection with a sale of assets held invalid); *Sacred Heart Hospital v. United States*, 616 F.2d 477, 483-84 (Ct. Cl. 1980) (Secretary's policy regarding reimbursement of costs for administration of medical provider's inhalation therapy department held invalid).

[13] *See, e.g., Humana of Aurora, Inc. v. Heckler*, 753 F.2d 1579 (10th Cir.), *cert. denied*, 474 U.S. 863 (1985); *Lloyd Noland Hospital & Clinic v. Heckler*, 762 F.2d 1561 (11th Cir. 1985); *DeSoto General Hospital v. Heckler*, 766 F.2d 182 (5th Cir. 1985); *Annie M. Warner Hospital v. Harris, 639 F.2d 961 (3d Cir. 1981)*; *AMI-Chanco, Inc. v. United States*, 576 F.2d 320 (Ct. Cl. 1978); *Biloxi Regional Medical Center v. Bowen*, 835 F.2d 345 (D.C. Cir. 1987); *Charlotte Memorial Hospital & Medical Center, Inc. v. Bowen*, 860 F.2d 595 (4th Cir. 1988); *Community Hospital of Indianapolis, Inc. v. Schweiker*, 717 F.2d 372 (7th Cir. 1983); *Columbus Community Hospital, Inc. v. Califano*, 614 F.2d 181 (8th Cir. 1980); *Guernsey Memorial Hospital v. Sullivan*, 996 F.2d 830 (6th Cir. 1993); *Faulkner Hospital Corp. v. Schweiker*, 702 F.2d 22 (1st Cir. 1983); *Memorial, Inc. v. Harris*, 655 F.2d 905 (9th Cir. 1980).

reasonable costs incurred in support of its GME programs, in accordance with the findings of the PRRB.

Respectfully submitted,

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Dated: April 11, 1994

APPENDIX

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Omnibus Reconcilation Act of 1980,
P.L. No. 96-499 *enacting*
42 U.S.C. § 1320b-4

For purposes of determining, under titles V, XVIII, and XIX of this Act, the reasonable costs of services provided by nonprofit hospitals, the following items shall not be deducted from the operating costs of such hospitals:

(1) A grant, gift, or endowment, or income therefrom, which is to or for such a hospital and which has not been designated by the donor for paying any specific operating costs.

(2) A grant or similar payment which is to such a hospital, which was made by a governmental entity, and which is not available under the terms of the grant or payment for use as operating funds.

(3) Those types of donor designated grants and gifts (including grants and similar payments which are made by a governmental entity), and income therefrom, which the Secretary determines, in the best interests of needed health care, should be encouraged.

(4) The proceeds from the sale or mortgage of any real estate or other capital asset of such a hospital, which real estate or asset the hospital acquired through gift or grant, if such proceeds are not available for use as operating funds under the terms of the gift or grant.

* * * *

House Conference Report No. 1479
Omnibus Reconciliation Act of 1980

Nonprofit Hospital Philanthropy

House Bill. -- The House bill provides that grants, gifts, and income from endowments, whether restricted by the donor or not (as well as certain income from philanthropic gifts, and other funds) shall not be deducted from operating costs of nonprofit hospitals in determining reimbursement under the medicare, medicaid and Maternal and Child Health programs.

Senate amendment. -- No provision.

Conference agreement. -- The conference agreement modifies the House provision to specify that the following items shall not be deducted from the operating costs of nonprofit hospitals in determining reimbursement amounts: (1) grants, gifts or endowments, and the income therefrom, which have not been designated by the donor for paying any specific operating costs; (2) governmental grants or similar payments, under the terms of which the grant or payment is not available for use as operating funds; and (3) the proceeds from the sale or mortgage of any real estate or other capital asset which the hospital acquired through gift or grant and which, under the terms of the gift or grant, are not available for use as operating funds (except for recovery of the appropriate share of depreciation when gains or losses are realized from the disposal of depreciable assets.)

In determining reimbursement amounts, the Secretary would continue to have authority not to deduct from operating costs certain types of donor-designated gifts and grants (including government grants) if he or she determines that it would be in the best interest of needed health care not to make a deduction with respect to such types of grants or gifts. It is intended the exemption currently contained in regulations relating to family practice training grants would be continued.

It is the intent of the conference committee that the prohibition against deducting gifts, grants, endowments, and income therefrom, shall apply indirectly as well as directly and

preclude the Secretary from taking into account the presence of charitable funds generated from gifts, grants or endowments which have not been designated by the donor for paying any specific operating costs as a reason for denying any reimbursable expense, such as interest expense.

42 C.F.R. § 405.481(a)

(a) Definition. For purposes of this subpart, physician compensation costs means monetary payments, fringe benefits, deferred compensation and any other items of value (excluding office space or billing and collection services), a provider or other organization furnishes a physician in return for the physician's services. Other organizations are entities related to the provider within the meaning of § 413.17 of this chapter, or entities that furnish services for the provider "under arrangements" within the meaning of the Act.